

Step 1	Read the entire application and complete Part A.
Step 2	If you are providing legal authority to another party to complete this application and/or act as your agent in the processing of this application, please be sure to complete Section 11. If not, leave this section blank.
Step 3	<p>Send or take your Application Part B to your Healthcare/Disability Professional. You should choose the provider who has the most knowledge of your disability/health condition.</p> <p>Part B may be filled out and signed by any of the following:</p> <ul style="list-style-type: none"> • Vocational Rehabilitation Counselor • Physical Therapist • Physician • Ophthalmologist • Licensed Clinical Social Worker • Audiologist • Physician's Assistant • Optometrist • Respiratory Therapist • Independent Living Specialist • Nurse Practitioner • Psychologist • Occupational Therapist • Speech and Language Pathologist • Psychiatrist/Psychiatric Social Worker
Step 4	Please ensure that all questions have been answered and that Part A is signed by you and that Part B is signed by your Healthcare/Disability Professional. Missing signature(s) may delay the processing of your application.
Step 5	<p>If this is your first time applying for MobilityLink Service, please contact the Certification Office by calling 410-764-8181 selecting Option 6 to schedule an appointment.</p> <p>If this is a recertification: Once Part A and Part B are completed and signed, please return the application to MTA by one of the following methods.</p> <p>Mail: ATTN: MobilityLink Certification Office, 1st Floor, 4201 Patterson Ave., Baltimore, MD 21215</p> <p>Fax: (410) 764-7526</p> <p>Email: MTACertification@mdot.maryland.gov</p>

Post Submission	<p>Recertification Applicants: Once your application is received, a member of our team will call you on the phone number listed on your application to complete a brief telephone interview. This interview should take approximately 20 minutes. You will not receive your determination on the day of the interview.</p> <p>All Applicants: MTA has up to 21 days to make a determination from your interview or in person functional assessment. If a determination has not been made within 21 days, you will be granted presumptive eligibility until a decision on your eligibility can be made. If it is determined you are not eligible or conditionally eligible for Mobility service, the determination letter will provide you with the details on how to appeal the decision. You have 60 days to appeal a determination. You can obtain information about the appeal process or other information about Mobility service by exploring our website at mta.maryland.gov/mobility.</p>
Need Assistance?	<p>If you need help understanding this information or assistance in completing or understanding Mobility forms or policies, wish to request a reasonable accommodation or modification, or need a copy of this document in an alternative format, please contact Mobility Information at 410-764-8181 or MD Relay 711. You may also contact the Office of Equal Opportunity Compliance Programs at 410-767-3944.</p>

Part A: Applicant Information (please print)

This section to be completed by the applicant, the applicant's caregiver, or another individual familiar with the applicant's disability. Please attach supplement documentation if additional space is required to thoroughly answer all questions.

Section 1: Application Type

☐ New Application ☐ Recertification If Recertification, Mobility #

Section 2: Demographic Information

Last Name		First Name		Middle Initial	
Street Address				Apt #	
City		State		Zip Code	
Mailing Address (if Different from Street Address)				Apt #	
City		State		Zip Code	
Home Phone			Mobile Phone		
Date of Birth (MM/DD/YYYY)		Email Address			

Section 3: Emergency Contact Information

Last Name		First Name	
Phone Number		Relationship	

Section 4: Transit Usage

1.	Have you used MTA buses, light rail, or metro subway? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
2.	Are you able to reach the MTA Bus Stop or Train Station nearest your home? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered "No" or "Sometimes", please explain.	

	What best describes your ability to use MTA's fixed route service? <input type="radio"/> I can use the MTA buses and train for most trips. <input type="radio"/> I can use MTA buses and trains, but it would be difficult. <input type="radio"/> I can use the MTA buses and trains, but only for specific trips or destinations. <input type="radio"/> I have never tried to use the MTA buses or trains. <input type="radio"/> I cannot use the MTA buses or trains without the assistance of another person. <input type="radio"/> I cannot use MTA buses and trains at all.
	Please explain your answer to question 4.

Section 5: Disability/Health Condition Information

1.	What is the primary disability or health condition that prevents you from being able to use MTA's buses and trains? Please be specific. 	
	Date of Diagnosis or Onset	
2.	Do you have other disabilities or health conditions that limit your ability to use MTA's buses and trains? <input type="radio"/> Yes <input type="radio"/> No	
	If "Yes", please explain.	
3.	Do the effects of your disability or health condition vary from day to day? <input type="radio"/> Yes <input type="radio"/> No	
	If "Yes", please explain.	
4.	Is your disability/health condition permanent or temporary? <input type="radio"/> Permanent <input type="radio"/> Temporary	
	If "Temporary", please explain.	

Section 6: Mobility Aids

1.	Check any and all mobility equipment that you expect to use while traveling: <input type="radio"/> Cane <input type="radio"/> Braces <input type="radio"/> Crutches <input type="radio"/> Walker <input type="radio"/> White Cane <input type="radio"/> Manual Wheelchair <input type="radio"/> Motorized Wheelchair <input type="radio"/> Service Animal <input type="radio"/> Scooter <input type="radio"/> Respirator/Oxygen <input type="radio"/> Other:	
2.	If you use a wheelchair or scooter, what is the width and length (in inches)? Length in inches: Width in inches:	
3.	Do you require the assistance of another person during travel or at your destination? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never If "Always" or "Sometimes", please explain.	

Section 7: Functional Skills

Without the help of someone else, can you...

1.	Ask for and understand written or spoken instructions? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never If "Sometimes" or "Never", please explain.	
2.	Cross the street? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never If Sometimes or "Never", please explain.	
3.	Stand for 20 minutes if there is no place to sit? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never If "Sometimes" or "Never", please explain.	

4.	Step on and off a sidewalk from a curb? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never	
	If "Sometimes" or "Never", please explain.	
5.	Walk on uneven surfaces? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never	
	If "Sometimes" or "Never", please explain.	
6.	Stand on a moving bus or train if there is a handrail? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never	
	If "Sometimes" or "Never", please explain.	
7.	Transfer from one bus or train to another? <input type="radio"/> Always <input type="radio"/> Sometimes <input type="radio"/> Never	
	If "Sometimes" or "Never", please explain.	
8.	What is the farthest that you can travel outdoors (using your mobility aid if you use one) without the aid of another person? <input type="radio"/> Less than 1 Block <input type="radio"/> 1-4 Blocks <input type="radio"/> More than 4 Blocks	
9.	<p>Please provide any other information about your disability or health condition that would help us better understand your travel abilities.</p>	

Section 8: Travel Training

1.	Have you ever had travel training to learn how to travel around the community or how to use MTA buses and trains? <input type="radio"/> Yes <input type="radio"/> No
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Section 9: Voter Registration

1.	Would you like to register to vote? <input type="radio"/> Yes <input type="radio"/> No
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Section 10: Certification

I understand that the purpose of this application is to determine if there are times when I cannot use MTA Fixed Route buses, subway, and light rail and I will require paratransit services. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I hereby certify, under penalty of perjury, that the information submitted is true and correct. I understand that providing any false information on this application may constitute a crime punishable under the law. Further, I understand that providing false or misleading information could result in the denial of my application or termination of my eligibility.

I give permission for MTA Mobility Certification staff to contact the professional who has filled out this application or given supplemental verification of my condition.

 Applicant Signature:	Date:
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OPTIONAL - Section 11: Authorization for Assistance with the Application Process

Please complete the authorization below if you are providing legal authority to another party to complete this application and/or act as your agent in the processing of this application.

Applicant Last Name		Applicant First Name		Applicant Middle Initial	
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I would like to apply for Mobility door to door paratransit service.

I am appointing _____ to help me apply for Mobility service. For this purpose, only, he or she has the authority to act on my behalf, including scheduling appointments, completing paperwork, and providing information about me to the Maryland Transit Administration (MTA), so long as it relates to my application for Mobility service.

MTA may release any information it has about me upon request, to this person, including health care information, so long as it relates to my application for services. For this purpose, only, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA) and is entitled to request, receive, and review protected health information: any information, oral or written, regarding my physical or mental health, including but not limited to medical and hospital records, and other protected health information. My agent may also consent to disclosure of this information.

This agreement expires: (Select from the options below.)

- ☒ At the end of my certification appointment.
☒ At the end of the Mobility Certification process and any applicable appeal process.
☐ On a specified date -

 Applicant Signature:	Date:
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Part B: Healthcare Provider Certification

Applicant Name		Mobility ID # <small>(if current rider)</small>	
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Section 1: General Information

Healthcare Professional Name	
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Title	
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Facility/ Institution/ Agency	
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License Number		State Issued	
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Mailing Address		Suite	
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City		State		Zip Code	
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Phone #	()	-	Fax #	()	-
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Email Address	
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Section 2: Disability/Medical Condition

Written Diagnosis <small>(List all)</small>	
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ICD-10 / DSM Codes	
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1.	How long have you been treating the applicant?	
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2.	When was the last time you saw (including virtual visits) the patient?	
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3.	What is the expected duration of the disability / medical condition? <input type="radio"/> Short Term (Likely to Improve within 1 year) <input type="radio"/> Long Term (Little expectation of improvement)
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4.	How does the disability or health condition impact the applicant's ability to independently travel on MTA buses or trains?

5.	Check any and all mobility equipment that the applicant requires: <input type="radio"/> Cane <input type="radio"/> Braces <input type="radio"/> Crutches <input type="radio"/> Walker <input type="radio"/> White Cane <input type="radio"/> Manual Wheelchair <input type="radio"/> Motorized Wheelchair <input type="radio"/> Service Animal <input type="radio"/> Scooter <input type="radio"/> Respirator/Oxygen <input type="radio"/> Other:

6.	Is the applicant currently on any medications with side effects that may significantly reduce or hinder their ability to independently ride the accessible MTA fixed route service? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes
	If you answered "Yes" or "Sometimes", please list those medications and explain.

7.	Does the applicant have a cognitive disability? <input type="radio"/> Yes <input type="radio"/> No
	If you answered "Yes", please explain the limitations imposed on independent transit travel because of the disability.

8.	Does the applicant have a seizure disorder? <input type="radio"/> Yes <input type="radio"/> No	
	If you answered "Yes", what was the date of the last known seizure?	
	If you answered "Yes", are the seizures controlled with medication?	<input type="radio"/> Yes <input type="radio"/> No

Section 3: Transit Usage

1.	Does the applicant have any challenges with memory? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	
2.	Would the applicant be able to recognize and avoid dangers when traveling alone in the community? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “No” or “Sometimes”, please explain.	
3.	Would the applicant be able to independently seek assistance if they were lost in the community? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “No” or “Sometimes”, please explain.	
4.	Would temperature extremes affect the applicant’s ability to ride transit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	
5.	Would ice and/or snow affect the applicant’s ability to ride transit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	

6.	Would poor air quality affect the applicant's ability to ride transit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered "Yes" or "Sometimes", please explain.	

7.	Does the applicant have any challenges with balance or gait? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered "Yes" or "Sometimes", please explain.	

8.	Does the applicant have a psychiatric condition that may impact functional ability? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered "Yes" or "Sometimes", please explain.	

9.	Does the applicant have any challenges with breathing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered "Yes" or "Sometimes", please explain.	

10.	Does the applicant have any challenges with strength and endurance? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered "Yes" or "Sometimes", please explain.	

11.	Does the applicant have any challenges with ambulating on hills? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	

12.	Are there any visual impairments that would affect this applicant’s ability to ride transit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes
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	If you answered “Yes” or “Sometimes”, please explain.	
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13.	Are there any hearing impairments that would affect this applicant’s ability to ride transit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	

14.	Does the applicant exhibit any inappropriate social behaviors? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	

15.	Do you have safety concerns for this applicant in using the fixed route service independently? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	

16.	Does the applicant require the assistance of another person while traveling or at their destination? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
	If you answered “Yes” or “Sometimes”, please explain.	

17.	In your medical opinion, what other factors related to the applicant's disability(ies) affect their ability to ride MTA buses or trains?

Section 4: Certification

I certify that I am licensed/certified and am currently treating_____.

I certify that all information provided in this application is a fair representation of the applicant's disability(ies) or health condition(s) and is true and correct.

I understand that the information provided will be used for the purpose of determining the applicant's eligibility for ADA paratransit service.

I agree that MTA and its eligibility contractor may contact me for clarification of any information I have provided and that I will reply with good faith.



Healthcare Provider Signature:

Date: